jectively observed for several years are meaningless when you deal with a disease as complex as psoriasis. I hope that the readers of the earlier letter did not advise the elimination of fruits and milk to their patients. I do not want to refer these patients to my fellow internists with preliminary diagnoses of vitamin deficiencies and calcium loss.

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Laboratory Evaluation of Neurosyphilis

TO THE EDITOR: The article "Neurosyphilis: An Update" by Dr. Roger Simon in the January 1981 issue was excellent. One major and very important aspect of the laboratory evaluation of neurosyphilis was, however, left unmentioned. I refer to the *Treponema pallidum* hemagglutination test (so-called TPHA), also known as the MHATP (microhemagglutination *Treponema pallidum).* Increasing evidence indicates that this test will replace the more expensive FTA-ABS (fluorescent treponemal antibody absorption) test for evaluation of biological false positive results for syphilis. The only apparent drawback of the MHATP is some decrease in sensitivity in primary syphilis; under those circumstances an FTA-ABS would be indicated.

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The Prevention of Nuclear War as a Medical Priority

TO THE EDITOR: What is the role of physicians in the prevention of nuclear war? Recently, two physicians approached the organized medical community with this question. Speaking before the Board of Trustees of the American Medical Association, Howard Hiatt, MD, Dean of the Harvard School of Public Health, suggested that "Talk of the use of nuclear weapons is a kind of epidemic . . . but with the term epidemic stretched beyond any meaning previously known."[1] Roger Bulger, MD, President of the University of Texas Health Sciences Center in Houston, wrote in the September 12, 1980, issue of the *Journal of the American Medical Association* that ". . . we as physicians have the obligation to transmit to our fellow citizens the nature of the effects of a nuclear war on us and the whole human race."[2]

Eighteen years ago, a group of physicians took up this question and published an article entitled "The Medical Consequences of Thermonuclear War," in the *New England Journal of Medicine.*[3] The introduction reminded readers that ". . . there are some situations in which prevention is the only effective therapy. It is hoped that readers . . . will be stimulated to play a greater part in the search for peaceful alternatives to thermonuclear war."

If physicians should accept a role in the prevention of this ultimate medical catastrophe, it is then necessary to consider factors that either increase or decrease the likelihood of nuclear war. It is here that the organized medical community has traditionally declined to become involved, observing that these considerations are outside the boundary of medical expertise. I would like to suggest that in several critical areas medical expertise can make an important contribution. These areas include the following:

- The need to estimate the injury, death and disease that result from nuclear detonations.
- The need to estimate the likelihood of accidental nuclear war due to the failure of technology and technology control.
- The need to estimate the likelihood of intentional nuclear war initiated by psychologically disturbed persons.

A recent *Scientific American* inquiry suggests that a serious underestimation exists among some military analysts of the destructive effects of nuclear weapons on health and the environment.[4] This error may have led to the formulation of the new strategy of limited nuclear war. The effects of such a limited exchange may be far greater than realized and may lower the risk threshold for all-out nuclear war.[5]

The editors of *The New York Times* were recently alarmed by the failure of an electronic circuit (worth 46 cents) at the Strategic Air Command that twice led to the incorrect perception of a Soviet nuclear attack within a three-day period.[6] As physicians familiar with machinery upon which life depends we are cognizant of the potential for failure often inherent in complex systems. We are all aware of the occasional morbidity and mor-

tality secondary to the malfunction of hardware such as respirators and heart-lung bypass devices. And we are all familiar with the rare but occasional failure of the well-trained operators of such equipment. Whereas in our medical practice technological malfunction may affect the health of one patient, in the arena of the command and control of nuclear weapons it may lead to global holocaust.

Finally, as physicians and scientists, we recognize the potential for the best of planning to be sabotaged by disturbed persons. A glance at any daily newspaper informs us of the prevalence of this instability, too often present in the leaders of certain developing nations. It is thus most disturbing to know that the international availability of nuclear fuels for electricity generation is leading to the soon irreversible proliferation of nuclear weapons.[7]

It is quite likely that a medical contribution would result in an increased appreciation of the medical damage from nuclear detonations and an increased appreciation of the likelihood of nuclear war due to technological error or psychological aberration. This could be an invaluable contribution to the deliberations of policy makers who wish to increase the security of our country and the security of the world.

I strongly urge that the medical profession as a whole consider the question of physicians' role in the prevention of nuclear war. The continued evolution of our civilization, our science and our grandchildren may await our timely answer.

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HAFE in Nepal

TO THE EDITOR: I enjoyed very much the correspondence regarding high altitude flatus expulsion (HAFE) in the February 1981 issue.[1] It brought back memories of service in Nepal. In the late 1960's problems began to appear as climbers were flown by helicopter, with very rapid gain in altitude, from the relatively low Kathmandu to high-level staging areas for assaults on major peaks. During these flights the HAFE phenomenon caused a number of unpleasant discussions and one colon rupture. When we discussed this with expedition guides we found that the problem had been long recognized. We published our findings in 1972, in the *Kathmandu Medical Bulletin,* in the article "Flatulence Accompanying Rigorous Trekking."

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Hypophosphatemia: Correct Quantity of 50 Percent Magnesium Sulfate

TO THE EDITOR: I am writing in regard to the fine review of hypophosphatemia by Dr. James P. Knochel which appeared in the January issue.[1] The article was very well written and well referenced, and gave very useful and timely advice on management of the condition. Unfortunately, the last paragraph of text contains a serious error of potentially great clinical significance: a solution is discussed that contains, among other components, "20 ml of 50 percent magnesium (16 mEq of magnesium)." However, 20 ml of 50 percent magnesium sulfate contains 80 mEq of magnesium, not 16. The administration of the stated solution three times a day for several days could conceivably lead to symptomatic magnesium intoxication.

I feel that every effort should be made to correct this error for the journal's readers because many people will want to employ Dr. Knochel's recommendation.

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Dr. Knochel Replies

TO THE EDITOR: In my review "Hypophosphatemia" an error was made for the dosage of 50 percent magnesium sulfate ($MgSO_4 \cdot 7H_2O$). The correct quantity of 50 percent magnesium sulfate that should be administered intravenously is 4 ml every eight hours. This volume contains 16 mEq of magnesium. My gratitude is extended to Dr. Triplett for recognizing this error.

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